

153005

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	5	1	7	8	3											
												REG. NO.																
1 - STATE REGISTRAR			1. DECEASED NAME			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR				
			SANGIE									ADAIR			06			21--85		12		10PM						
3. SEX			4 RACE			\$ DATE OF BIRTH			MONTH			DAY			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS								
Female			Black			May 26, 1903									82			YRS.		MONTHS		DAYS		HOURS		MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 DATE OF BIRTH			MONTH			DAY			9 BALTIMORE CITY OR COUNTY OF DEATH													
S.C.			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>									PRINCE GEORGE'S COUNTY													
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)									12b. KIND OF BUSINESS OR INDUSTRY													
CHEVERLY			PRINCE GEORGE'S GENERAL HOSP.			Housewife									At Home													
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			20855													
Md.			P.G. Deanwood PK			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						4709 Deanwood			. Dr.													
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME			FIRST			MIDDLE			Unknown													
Obie			Pitts			ADDRESS																						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT																						
No			218-20-1420D			Delores Harris-Same as # 13 above																						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Pneumonia, Aspiration</u>																												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Brain Syndrome</u>																												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Urinary Tract Infection</u>																												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																			
6-6-85.			(R) G.L. Cavity R/o Ca.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. - 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. LOCATION STREET			21e. CITY OR TOWN			21f. COUNTY			21g. STATE										
21h. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21i. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21j.			N/A			N/A																
22a. I certify that (I) (this hospital) attended the deceased from 6-4-85, 19 85, to 6-20-, 19 85, that (I) (we) last saw the deceased alive on 6-20-85, 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE																
22c. DEGREE												22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22e. DATE SIGNED						
22f. PHYSICIAN'S NAME (TYPE OR PRINT)												22g. ADDRESS										22h. DATE REC'D. BY REGISTRAR			22i. REGISTRAR'S SIGNATURE			
Raman R-Tuli MD												16220 FREDERICK RD, GAITHERSBURG, MD.										Jul 08 1985			Julie Davidson-Kendall			
23a. BURIAL			CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE										
BP			6/27/85			HARMONY MEM. PARK						LANNOVER, P.G., MD.																
24. FUNERAL DIRECTOR NAME												25a. ADDRESS										25b. DATE REC'D. BY REGISTRAR			25c. REGISTRAR'S SIGNATURE			
H.S. WASHINGTON & SONS												4925 Barneoughs Ave, N.E. JUL										0 8 1985			Julie Davidson-Kendall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

area of the city
and the position of
the city center in
relation to the

184052

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201.

07/84
25MBP _____
DHMH - T7
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17832

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR 6/19/ 1985	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR 6:00P	
Male	White	June 13, 1938	47 yrs.			6/ 19/ 85					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		U.S.A.				Prince George's County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Capital Heights		716 Ritchie Road		Mechanic		Automobile					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Maryland		P.G. Co.		Seat Pleasant		6800 Grieg St. 20743					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
William		F.		Andrews		Nina		I.		Rakes	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		229-46-4886		Mrs. Catherine D. Andrews/ Same as # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 6/ 19/ 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject hanged self							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) residence		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 716 Ritchie Rd., Capital Heights, Pr. Geo., Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural caus <input type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE _____											
TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER											
DATE SIGNED 6/20/85											
EXAMINER'S NAME (TYPE OR PRINT)		Gregory R. Kauffman, M.D.		ADDRESS		111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Cremation		6/21/85		Chambers Crematory		Riverdale		P.G.		Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		5801 Cleveland Ave.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W.W. Chambers CO. INC.				Riverdale Md. 20737		JUL 01 1985					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
retded by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed in the funeral director's office. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 5 1 7 3 3 3	
1. DECEASED NAME (TYPE OR PRINT) <i>Andrew Graysen Baden</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>6-28-88</i>				2b. HOUR 5:25 PM					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 4, 1896				6. AGE (IN YEARS LAST BIRTHDAY) 88		7. IF UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's					
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer				12b. KIND OF BUSINESS OR INDUSTRY Agriculture			
13a. STATE MD		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Brandywine		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14304 Brandywine Rd 20613					
14. FATHER'S NAME FIRST James		MIDDLE E.		LAST Baden		15. MOTHER'S MAIDEN NAME FIRST Roberta				MIDDLE Hudgison			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-36-6565				17. INFORMANT WIFE Marie B. Baden		ADDRESS same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio. Kidney Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardio Vascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <i>Oxygen</i> DUE TO, OR AS A CONSEQUENCE OF years												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 8-12							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 6-27-74				21f. LOCATION STREET CITY OR TOWN COUNTY STATE		6-26-88					
22a. I certify that (I) (this hospital) attended the deceased from 6-27-74, 1985, to 6-26-88, 1988, that (we) lost saw the deceased above on 6-27-74, and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) did not view the body after death.													
22b. SIGNATURE <i>Richard H. Dobson, M.D.</i>		22c. DEGREE M.D.				ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>6-28-88</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard H. Dobson, M. D.		22e. ADDRESS Brandywine, MD				23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/1/85		23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Cemetery		23d. LOCATION CITY OR TOWN Baden	
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, MD		25a. DATE REC'D. BY REGISTRAR JUL 01 1995				25b. REGISTRAR'S SIGNATURE <i>John Huntt</i>							

169077

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 5 1 7 8 3 4

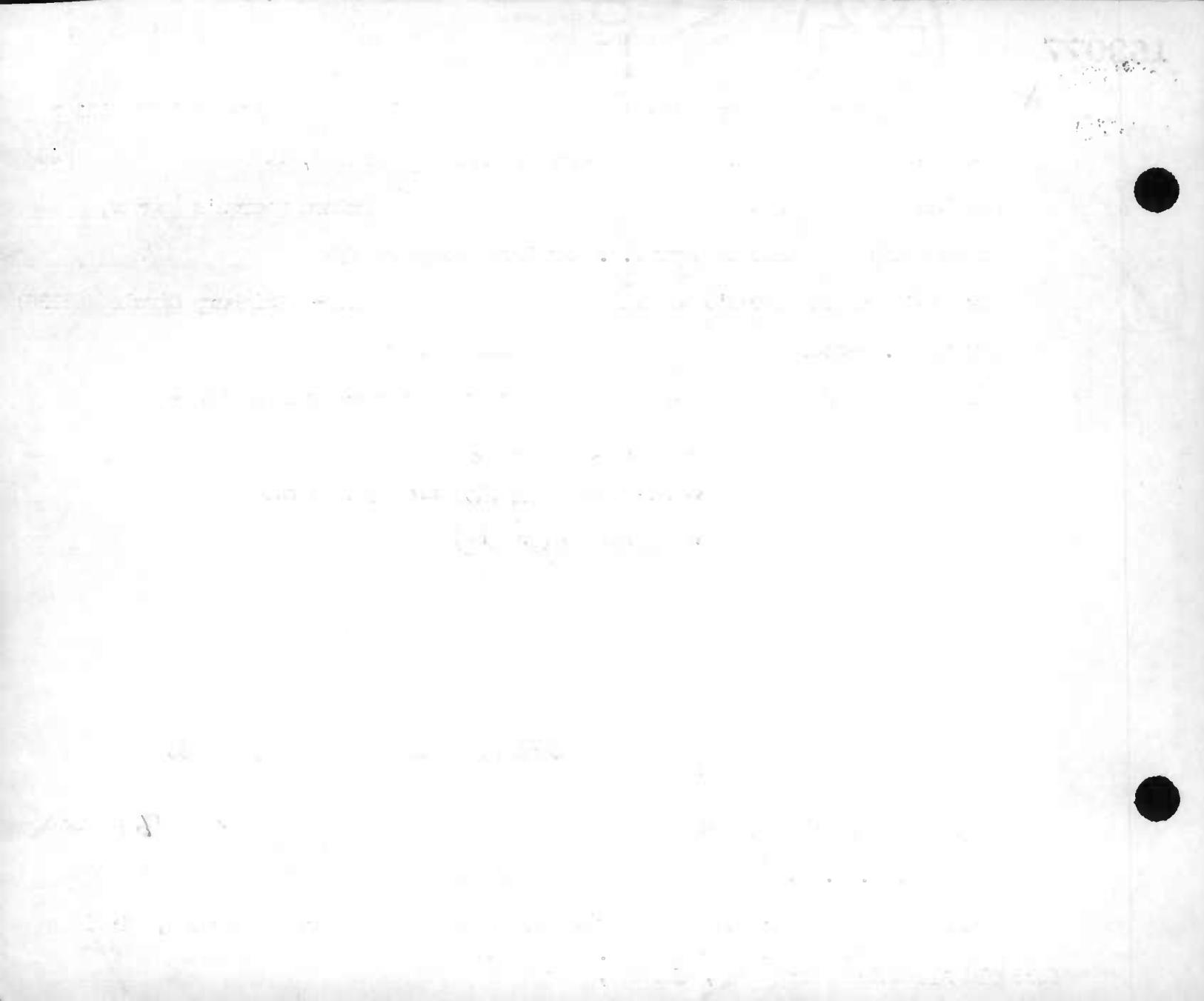
1 - STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
JENNIFER ALICIA BARBER						JUN 6 1985			1230P M				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
Female		Black		June 6, 1985					40				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		USA					Prince George's County, MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Andrews AFB		Malcolm Grow U.S. Air Force Hospital		N/A			N/A						
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Maryland		Prince George's		Bowling AFB			1627-B Reinburg Circle (20336)						
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Bernard A. Barber		Carol Dickens											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS						
No		N/A		None			Bernard Barber - Same As #13 A-E						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>multiple Congenital Abnormalities</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Prematurity (asuts)</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>June 6, 1985</u> to <u>June 6, 1985</u> , that (I) (we) last saw the deceased alive on <u>June 6, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Carol A. B. Rupe, MD</u> DEGREE													
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> 22c. DATE SIGNED <u>7 June 85</u>													
24a. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			Malcolm Grow USAF MC Andrews Air Force Base, Maryland 20331								
Carol A. B. Rupe, MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE		
Burial		June 12, 1985		Arlington National Cemetery			Arlington, Virginia						
24 FUNERAL DIRECTOR NAME		Lee Funeral Home, Inc.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
		Old Alexander Ferry Road, Clinton, Maryland						JUN 14 1985		<u>Leigh Anderson - Rupe</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or other traumatic event, the medical examiner must be notified at once.



8 00 178335

REG NO

by the funeral director, page 3
filed within 72 hours after death

by
filed

13

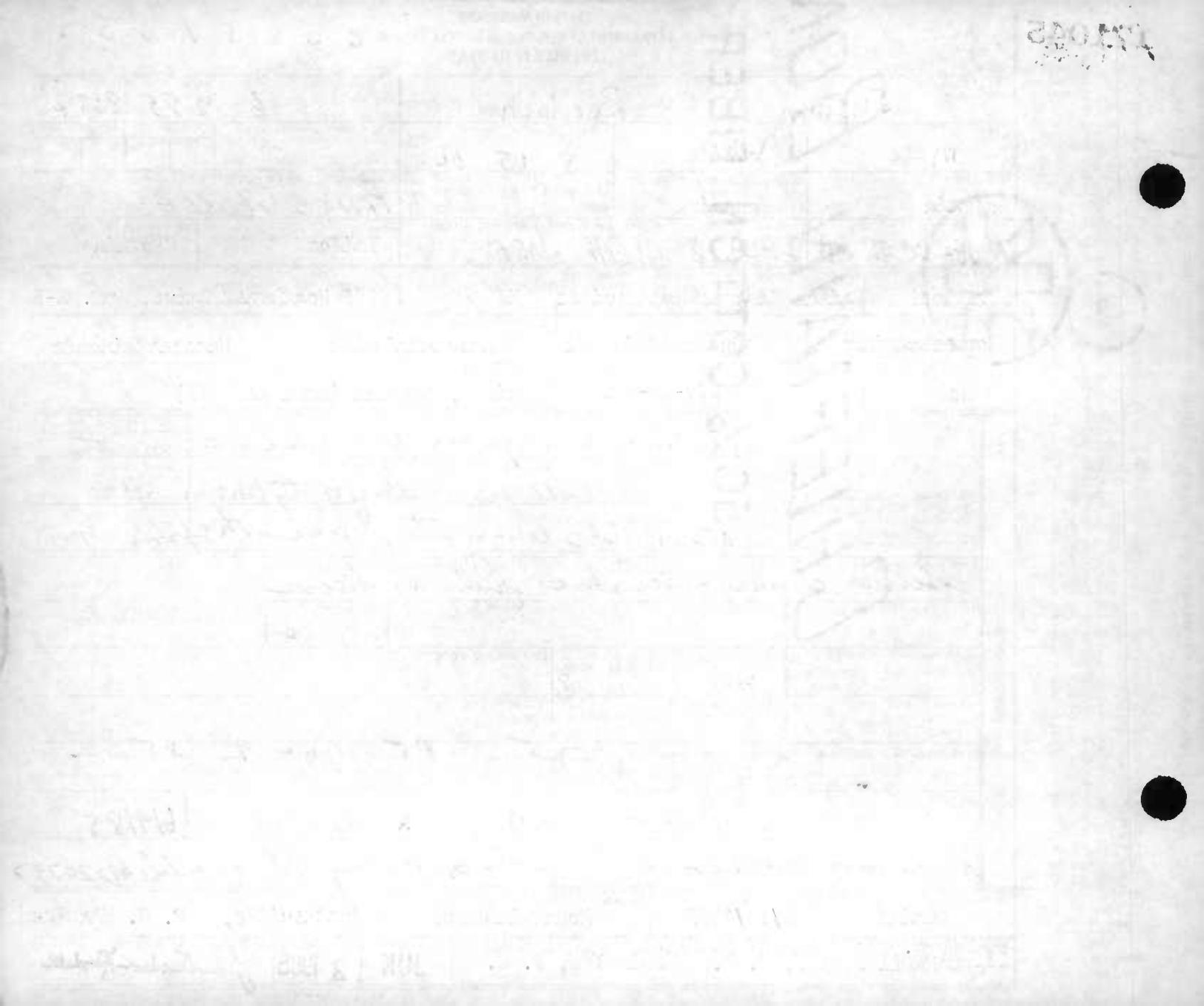
h certificate be
ding physician
carbon papers. P
or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The
attending physician or hospital should be retained by the hospital or attending physician.

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Susman					Bardach	6	9	85	835 p.m.			
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Male		White	MONTH	DAY	YEAR	79	YRS	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Austria		Canadian			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Prince Georges				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (PROVIDING SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
RIVERDALE MD		LELAND MEM. HOSP.			Tailor			Clothing				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8725 Northwest Drive, Apt. K-6				
Maryland		Prince Georges		Hyattsville				207				
14. FATHER'S NAME												
FIRST			MIDDLE	LAST			15. MOTHER'S MAIDEN NAME					
Unascertainable				Unascertainable			Unascertainable			Unascertainable		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			16c. INFORMANT			ADDRESS				
No		219-48-1820			Moris S. Bardach (Same as # 13)							
18. CAUSE OF DEATH (Enter only one cause per line for item (a), and up to three causes for items (b) and (c).)												
PART 1. DEATH WAS CAUSED BY												
IMMEDIATE CAUSE (a) <i>Intractable congestive heart failure with left pleural effusions.</i> monthly												
DUE TO, OR AS A CONSEQUENCE OF <i>Tobacco smoking history (smoker) years.</i>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.												
DUE TO, OR AS A CONSEQUENCE OF <i>atherosclerotic coronary artery disease with infarcts years.</i>												
(b) <i>Severe chronic obstructive pulmonary disease</i>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			months				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR - P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22. I certify that (I) (this hospital) attended the deceased from <u>May 5</u> , 19 <u>85</u> , to <u>June 9</u> , 19 <u>85</u> , that (I) (we) lost the deceased alive on <u>June 9</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I) did not view the body at the death.												
22g. SIGNATURE <i>Abraham Dabala</i>		22h. DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22i. DATE SIGNED <i>6/19/85</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
ABRAHAM DABELA		4404 Grosvenor Rd. Riverdale MD 20737										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION		COPY			
Burial		6/10/1985		Mount Lebanon			Hyattsville, MD		P. G. Maryland			
24. FUNERAL DIRECTOR STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <i>Juda Davidson-Pandell</i>			
JUN 12 1985												

20042



178020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in the presence of a physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	5	1	7	8	3	6
										REG. NO. 1						
1. DECEASED NAME (TYPE OR PRINT)		FIRST BERTHA		MIDDLE M.		LAST BARNES		2a DATE OF DEATH MONTH FEB.		MONTH 6	DAY 11	YEAR 85	2b. HOUR 7 20PM			
3. SEX FEMALE		4 RACE NEGRO		5. DATE OF BIRTH MONTH FEB.		DAY 10	YEAR 1919	6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS 6		IF UNDER 24 HRS HOURS 7				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY		MD.								
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY										
13a. STATE MARYLAND		13b. COUNTY P.G.		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7002 20TH. AVE. 20783								
14. FATHER'S NAME FIRST ROSCOE BARNES, SR.		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST JESSIE ADAMS		MIDDLE		LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 246-09-0216		17. INFORMANT ERNESTINE BARNES		ADDRESS HYATTSVILLE, MD 7002 20TH. AVE.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)																
DUE TO, OR AS A CONSEQUENCE OF																
DUE TO, OR AS A CONSEQUENCE OF																
DUE TO, OR AS A CONSEQUENCE OF																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
Bilateral cerebrovascular Accident																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)												
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>																
22a. I certify that (1) this hospital attended the deceased from saw the deceased alive on above (1) we did not see the body after death.		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 6/11 1985		21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
6/14 1985 to 6/11 1985																
22b. SIGNATURE Wm H. Yablonowits		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/12/85										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm H. Yablonowits MD		22e. ADDRESS 10300 Greenbelt Rd. #101 Seabrook														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/15/85		23c. NAME OF CEMETERY OR CREMATORIAL WASHINGTON NAT.		23d. LOCATION CITY OR TOWN SUITLAND, (PG) MARYLAND										
24. FUNERAL DIRECTOR NAME MORROW & WOODFORD, INC.		ADDRESS 1622 11TH. ST., NW WASH., D.C. 20001		25a. DATE REC'D. BY REGISTRAR JUN 18 1985		25b. REGISTRAR'S SIGNATURE Glen Seiden-Rendell										

OCTOBER

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17831

REG. NO.

171081

1- STATE
REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P-3. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
Evelyn			M.		Barnes	June 13	85		840	
4. RACE	5. DATE OF BIRTH MONTH DAY YEAR <small>YEAR IS BIRTHDAY</small>	16. AGE (IN YEARS MONTHS DAYS	17. IF UNDER 1 YR. MONTHS	18. IF UNDER 24 HRS. DAYS	19. IF UNDER 24 HRS. HOURS	20. IF UNDER 24 HRS. MIN.				
Female	White 04 06 1903 82									
7b. BIRTHPLACE, STATE OR FOREIGN COUNTRY Maryland		7c. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County				MD.
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Leland Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse		12b. KIND OF BUSINESS OR INDUSTRY Hospital				
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland		13b. COUNTY P.G.	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 4410 Oglethorpe Ave. #112 20781					
14. FATHER'S NAME William		MIDDLE O.	LAST Barnes	15. MOTHER'S MAIDEN NAME FIRST Dova		MIDDLE M.	LAST Baumgardner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-36-9586		17. INFORMANT Mabel B. Wilkinson (Sister) #110		ADDRESS 4410 Oglethorpe Ave.				
Hyattsville, MD BETWEEN ONSET AND DEATH										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial Dic</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last. (b) <i>Chronic myocardial Dic</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Yes</i>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>										
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>John L. Rogers, Jr.</i> M.D. TITLE (SPECIFY) EXAMINER'S NAME (TYPE OR PRINT) <i>Medical Examiner</i>										
ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 6/17/85		23c. NAME OF CEMETERY OR CREMATORIAL Linganore Cemetery		23d. LOCATION CITY OR TOWN Unionville		COUNTY	STATE	
24. FUNERAL DIRECTOR Francis Gasch's sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				25a. DATE REC'D. BY REGISTRAR JUN 18 1985		25b. REGISTRAR'S SIGNATURE <i>Davidson Kendall</i>				

1801

RECORDED
JAN 20 1981
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

SEARCHED SERIALIZED INDEXED

159009

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGES 5, 6, AND 7 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 17838			
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR				2b. HOUR			
MARY PEGGY BARNES								6 3 1985							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 35 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			
FEMALE		BLACK		MARCH 30, 50								6 3 1985			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.									
MARYLAND		UNITED STATES													
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSES AIDE				12b. KIND OF BUSINESS OR INDUSTRY PRIVATE					
13a. STATE MARYLAND		13b. COUNTY CHARLES		13c. CITY OR TOWN LA PLATA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 697 PISCATAWAY CT./ 20646							
14. FATHER'S NAME THOMAS		MIDDLE		LAST COOPER		15. MOTHER'S MAIDEN NAME MARY		MIDDLE		LAST COLE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Roland Barnes		ADDRESS Md. 20646		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8/51 IMMEDIATE CAUSE (a) Thoraco-abdominal trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? Head Only <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 11:18M. 6-2- 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Passenger of auto/fixed object impact.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET St. Mary's Ave., La Plata, Charles head Only <input checked="" type="checkbox"/>			CITY OR TOWN COUNTY STATE MD						
22a. I certify that I took charge of the remains described above, held an death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <i>[Signature]</i>						TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 5-4-85			
EXAMINER'S NAME (TYPE OR PRINT)			Ann M. Dixon, M.D.			ADDRESS 111 Penn St., Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE JUNE 7, 1985			23c. NAME OF CEMETERY OR CREMATORIAL ST. JOSEPH'S CHURCH			23d. LOCATION CITY OR TOWN POMFRET			COUNTY CHARLES MD.			
BURIAL															
24. FUNERAL DIRECTOR <i>[Signature]</i> THORNTON'S FUNERAL HOME						ADDRESS POMONKEY, MD.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			

20021



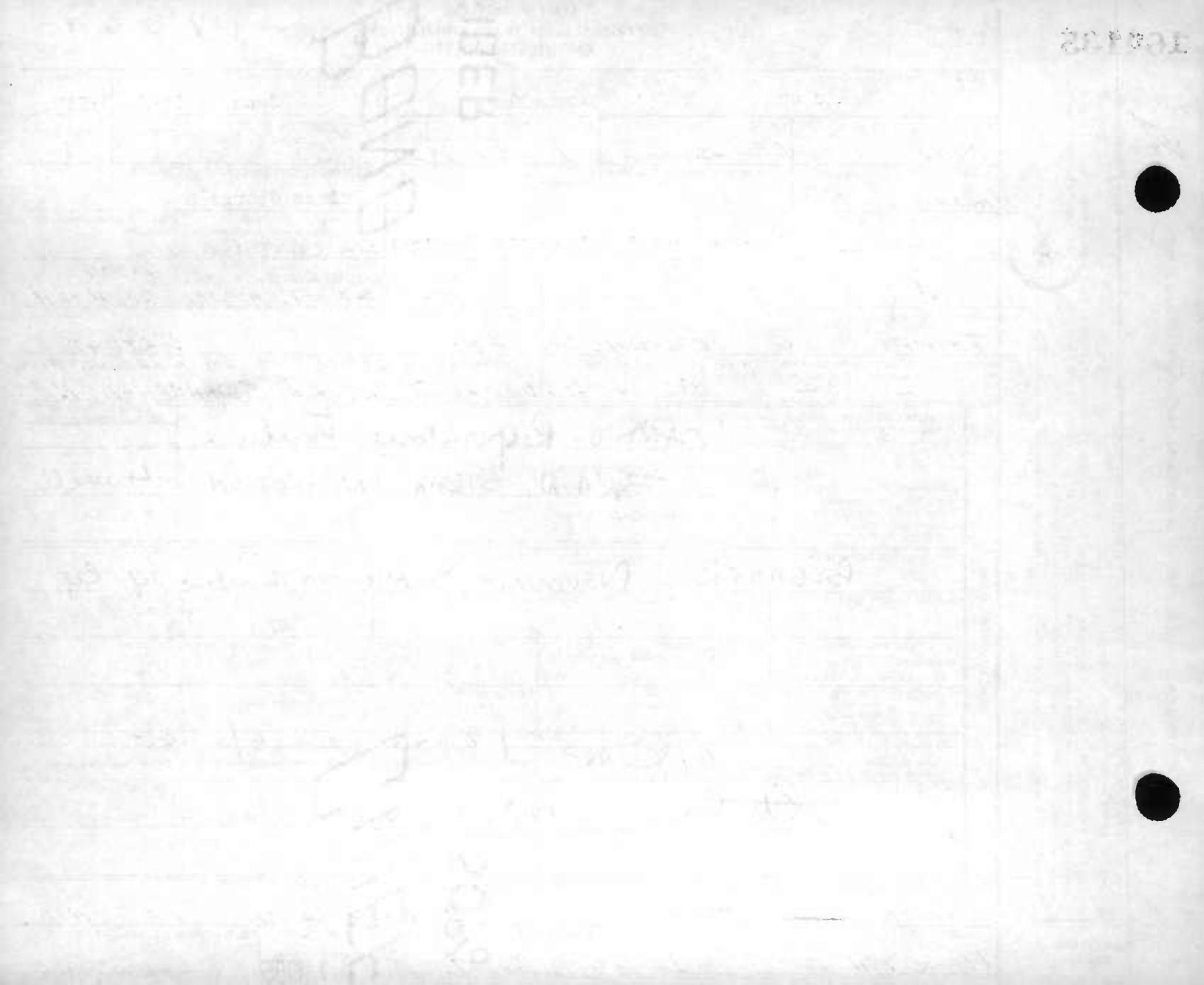
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMP. CERT. # Item 21 is marked or Item 28 shows any injury, or other traumatic event, the medical examiner must be informed at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 1 7 8 3 9			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			20. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Richard H. Barnwell								June 8, 1985						9:55P. M.	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS (LAST BIRTHDAY))			IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE			Caucasian			1 27 1927			58			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
ASHVILLE N.C.			U.S.						Prince George's						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13b. KIND OF BUSINESS OR INDUSTRY						
LAUREL			Greater Laurel Beltsville Hospital			SPACE CRATE Controller			20707						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
MD.			P.G.			LAUREL						200 FT. MEADE RD. #1211			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
THOMAS			O		BARNWELL Sr.	ADA					WRIGHT				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			28778 ADDRESS 209 RICHMOND AVE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
—			392-34-0613			DOROTHY B. McCRAIN			SWANNANOA, N.C.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			CARBIO- Respiratory Failure												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) BRAIN STEM INFARCTION			DUE TO, OR AS A CONSEQUENCE OF (c)						4 week			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
BILATERAL PNEUMONIA, Deep Venous Thrombosis left leg.															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) close the body after death.			5/8 1985			6/8 1985									
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						MD.									
22e. ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE		
Cremation			6/11/85			BALTO. WASH. Crematory			LAUREL			PG	MD.		
24. FUNERAL DIRECTOR NAME			ADDRESS			7601 SANDY SPR. RD.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
FLECK F.H. INC.						LAUREL, MD. 20707			JUN 11 1985			G. Fleck			

2020.1



168081

1/27/85 Items 4-7, 13-13e L.J.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 17840

FOR
1 - STATE Film G607, items 13a, b, c, d, 14, 15, 9/4/85 fja

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be held without the hourglass seal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Baby</i>	MIDDLE <i>Pernell Alvin</i>	LAST <i>Clayton I. BATTLE</i>	2a. DATE OF DEATH MONTH <i>4</i>	DAY <i>25</i>	YEAR <i>85</i>	2b. HOUR <i>4:41PM</i>
3. SEX <i>Black</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH <i>4</i>		DAY <i>25</i>	YEAR <i>85</i>	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS <i>infant</i>		IF UNDER 24 HRS DAYS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN (COUNTRY) <i>Cheverly</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>PRINCE GEORGE'S COUNTY MD.</i>		
10. CITY OR TOWN OF DEATH <i>CHEVERLY</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>PRINCE GEORGE'S GENERAL HOSPITAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. COUNTRY <i>Md.</i>		13c. CITY OR TOWN <i>Cheverly</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1021 58th Ave. 20743</i>		
14. FATHER'S NAME FIRST <i>Pernell</i>		MIDDLE <i>Alvin</i>	LAST <i>Clayton I</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Angela Marie</i>		MIDDLE <i>Battle</i>	LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
DO TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DO TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Kathlyn A. Hamilton</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5-3-85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>KATHLYN HAMILTON MD.</i>		22e. ADDRESS <i>PGGH CHEVERLY MD. 20785</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>5/7/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Prince George's Hosp. Cheverly, PG, MD</i>		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <i>Raleigh Cline, Cheverly, MD 20785</i>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <i>JUN 14 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Jeanne Davidson-Pendall</i>		

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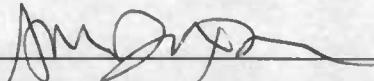
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Items 18-22a 7/24/85 mtb F#605 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17841

REG. NO.

I. DECEASED NAME (TYPE OR PRINT)			FIRST JOHN Philip	MIDDLE	LAST BAYER	2a. DATE KNOWN OF EST. DEATH MATED	MONTH X 6 9	DAY 19 85	YEAR	2b. HOUR
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7f. IF UNDER 1 YR.	7f. IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	MONTH 6 10	DAY 19 85	YEAR	2d. HOUR 11:30 AM
Male	White	July 3, 1957	27	MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Canton, Ohio		U.S.A.					Prince Georges County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Temple Hills		8408 Temple Hill Rd.			Stainless Steel Worker		20748			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS			
Maryland		Prince George		Temple Hill		YES <input checked="" type="checkbox"/>	8408 Temple Hills Rd.			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		LAST				
John		NMI	Bayer	Dorothy		R. Wallasik				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Father) 9658 ADT Blue Wing Dr.		John Bayer El Paso, Texas 79924				
Yes		465/13/8560								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Narcotism										
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE 										
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.										
ADDRESS 111 Penn St., Balto., MD 21201										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 6/14/85		23c. NAME OF CEMETERY OR CREMATORIAL Fort Bliss National		23d. LOCATION CITY OR TOWN El Paso		COUNTY El Paso		STATE Texas
Burial										
24. FUNERAL DIRECTOR NAME E. Barnes		ADDRESS 21018		25a. DATE REC'D. BY REGISTRAR JUN 13 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall				
Fleming Funeral Service		Benson, Md.								

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 17842

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST RACHEL	MIDDLE ELLEN	LAST BEALL	20. DATE OF DEATH MONTH DAY YEAR	JUNE 21, 1985	2b HOUR 06 21 85 50
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 100 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female	WHITE	OCT. 1, 1884	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
7a. BIRTHPLACE (STATE OR FOREIGN MD.)	7b. CITIZEN OF WHAT COUNTRY? USA	8. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Co. MD.					
10. CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Hyattsville Manor Nsc. None	12a. USUAL OCCUPATION H. MAKER		12b. KIND OF BUSINESS OR HOME			
13a. STATE MD.	13b. COUNTY MONT.	13c. CITY OR TOWN SILVER SPRING	14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 13931 Alderton Road 20906			
15. FATHER'S NAME THOMAS	E.	ODEN	15. MOTHER'S MAIDEN NAME CAROLINE	LAST CARTER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 216-22-0604D	17. INFORMANT William T. Beall		12185 Lime Kiln Rd. Fulton, Md. 20759			
18. CAUSE OF DEATH (Enter only one cause per line for Part I, II, and III). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a),		Acute congestive heart failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Time.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <i>Affluecenta Heart Disease</i>		5 yr			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110.							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost now the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) witness the body after death.							
22b. SIGNATURE <i>Myron L. Lenkin</i>		DEGREE	22c. DATE SIGNED 6/21/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. MYRON L. LENKIN		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22e. ADDRESS 2309 Shorefield Rd. Wheaton, Md. 20902				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JUNE 24, 1985	23c. NAME OF CEMETERY OR CREMATORIUM UNION CEMETERY	23d. LOCATION CITY OR TOWN BURTONSVILLE	COUNTY	STATE MONT. MD.	
24. FUNERAL DIRECTOR FRANCIS H. B ARBER		25a. DATE REC'D. BY REGISTRAR JUN 24 1985		25b. REGISTRAR'S SIGNATURE <i>Lelia Davidson-Randall</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-trust permit. This please remove carbon paper. This page 2 should be filed with the 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 there is any injury, or other traumatic event, this death certificate must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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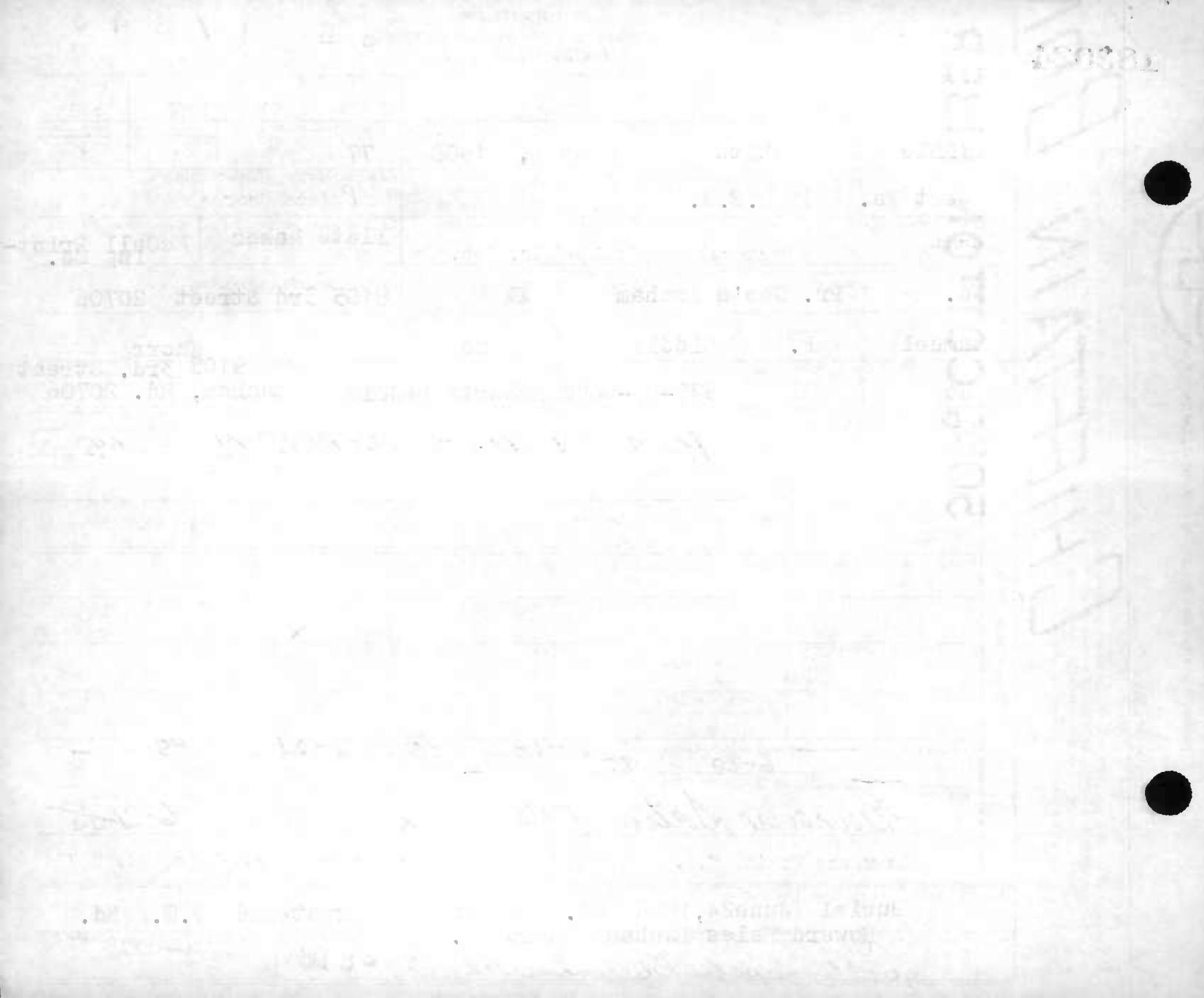
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retouched for use by the funeral director. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 21 is marked, the medical examiner must be informed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										5	1	7	8	4	3				
										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR									
WILLIAM J BIDDLE						JUNE	21	1985		9:45A M									
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR			IF UNDER 24 HRS								
Male			White	Month Day Year			77	MONTHS	DAYS	HOURS	YRS.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
West Va.			U.S.A.						Prince George's										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (IF DIFFERENT FROM MEDIUM OF DISEASE)			12b. KIND OF BUSINESS OR INDUSTRY										
Lanham			Doctors' Hospital of Pr. Geo. Co			Plate Maker			McCall Printing Co.										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE									
13b. COUNTY										13c. CITY OR TOWN									
Md.										Pr. Geo's Lanham									
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME			16. ADDRESS						
Samuel F. Biddle										Anna			9105 3rd Street Lanham, Md. 20706						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b. SOCIAL SECURITY NO.			17. INFORMANT			Knorr			
NO										577-09-8892			Roberta Biddle						
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION										4 DAYS									
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																			
(b) _____																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c) _____																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (the hospital) attended the deceased from 6-18, 1985, to 6-21, 1985, that (I) (we) last saw the deceased alive on 6-20, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																			
22b. SIGNATURE <i>Lawrence Satin, M.D.</i>										DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 6-21-85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence Satin, M.D.										22e. ADDRESS 7500 Hanover Parkway, Greenbelt, Md. 20770									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial June 24, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln			23d. LOCATION Brentwood			COUNTY	STATE						
24. FUNERAL DIRECTOR NAME			ADDRESS Howard Hales Lanham Funeral H. 9013 Annapolis Rd Lanham Md			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			JUN 26 1985							



184101

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 17844

REG. NO.

1 - STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
			ROBERT	L	BIGGERS	14 JUN 85				2249p M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
MALE		BLACK		MONTH	DAY	YEAR	64 yrs			IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8			9			YRS.		
October 1, 1920		United States			MARRIED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Camp Springs		Malcolm Grow Hospital			(Ret)Enlisted - U.S. Army								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			14. STREET ADDRESS / ZIP CODE				
Md.		Prince George		Suitland					2643 Shadyside, Ave. #104-20746				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS					
James Willis Biggers					Coty Bell Williams			4874 Conner Road #3					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			Columbus, Georgia 31983					
Yes, WWII, Korea, Viet Nam		577-20-2932			Dixie Lee Rome								
18. CAUSE OF DEATH (Enter only one cause per line for part 1 or part 2) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <input checked="" type="checkbox"/> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (or), stating the underlying cause lost. X DUE TO, OR AS A CONSEQUENCE OF X PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>14 June</u> 1985 to <u>14 June</u> 1985, that (I) (we) last saw the deceased alive on <u>14 June 85</u> 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		22c. DEGREE			22d. DATE SIGNED								
								14 Jun 85					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS			22g. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22h. DATE REC'D. BY REGISTRAR					
MARK ROLLO		Malcolm Grow Hospital, Andrews AFB											
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE 17 June 85		23c. NAME OF CEMETERY OR CREMATORIAL Lee Crematory		23d. LOCATION CITY OR TOWN Washington, DC			COUNTY	STATE			
24 FUNERAL DIRECTOR J. William Lee's Sons Company 300 4th St NE Washington, DC 20002		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 shall be mailed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

the question of whether or not it is
possible to have a self-sustaining
economy that does not pollute.
The answer is no.

179030

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 17845

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JAMES H. BLAKE				2a. DATE OF DEATH MONTH DAY YEAR 06-14-85	2b. HOUR 3 :30AM
3. SEX Male		4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR M 8 5 1924	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS 60	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S NURSING CARE CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
13a. STATE Maryland		13b. COUNTY P.G.	13c. CITY OR TOWN Seat Pleasant	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5600 Davey St., Seat Pleasant, Md. 20743
14. FATHER'S NAME George W. Blake		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Lillian Tolson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-18-0473	17. INFORMANT Mrs. Elnore Vaden (Sister) Landover, Md. 20785		ADDRESS 2112 Vermont Ave., Landover, Md. 20785
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____					
DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (c) CERERO VASCULAR ACCIDENT					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 1991 , 1985, to 6/13/1985 , to 6/14/1985 , that (I) (we) last saw the deceased alive on 6/13/1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A-Dashottar		DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A-DASHOTTAR MD		22e. ADDRESS 5632 ANNAPOLIS ROAD #7 BLADENSBURG Md. 20710			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-18-85	23c. NAME OF CEMETERY OR CREMATORIAL Harmony Mem. Park	23d. LOCATION CITY OR TOWN Landover, Maryland	COUNTY STATE
24. FUNERAL DIRECTOR Rollin's Funeral Home, Inc.		25. DATE REC'D. BY REGISTRAR SUN JUN 21 1985	25b. REGISTRAR'S SIGNATURE Julia Davidson Pendleton		
DHMH - 16 60M 7/84 (VRA 15, 4)					

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

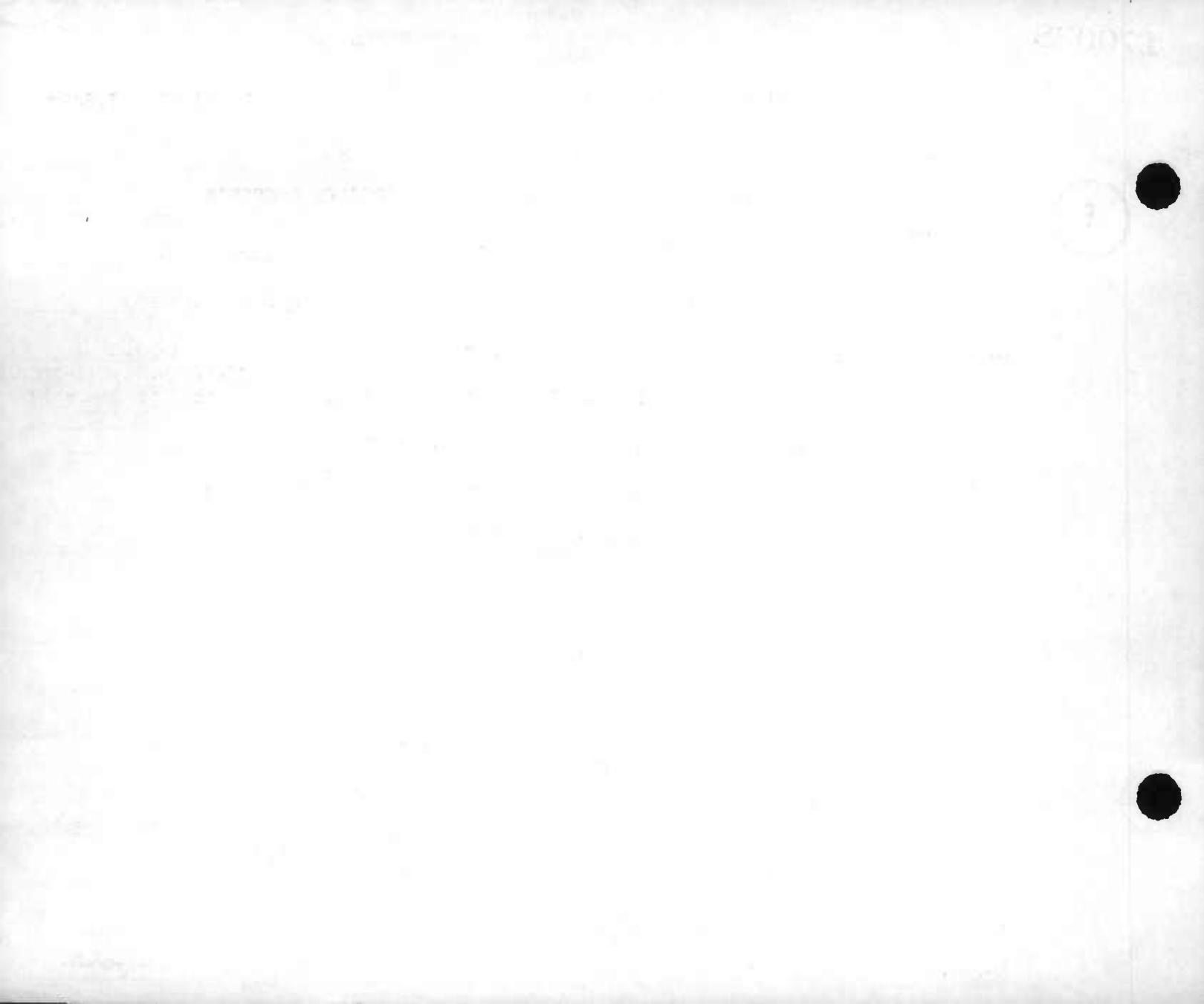
REG. NO.

8 5 1 7 8 4 6

1. DECEASED NAME (TYPE OR PRINT)			FIRST LILLIAN	MIDDLE S.	LAST BOBACK	2a. DATE OF DEATH	MONTH 06-01-85	DAY	YEAR	2b. HOUR 7.30PM
3. SEX Female		4. RACE White	5. DATE OF BIRTH MONTH 03 DAY 11 YEAR 05			6. AGE (IN YEARS LAST BIRTHDAY)	80	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S			MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Book Binder			12b. KIND OF BUSINESS OR INDUSTRY GPO		
13a. STATE Maryland		13b. COUNTY PG	13c. CITY OR TOWN Landover Hills		13d. INSIDE CITY LIMITS? X	13e. STREET ADDRESS / ZIP CODE 7020 Taylor Terrace 20784				
14. FATHER'S NAME FIRST James		MIDDLE E	LAST Smith	15. MOTHER'S MAIDEN NAME FIRST Emma		MIDDLE Pool	LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-26-7800		17. INFORMANT Christine Schafer		ADDRESS 1307 Shady Glenn District Hqts MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ANEST						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE										
DUE TO, OR AS A CONSEQUENCE OF (c) SYSTEMIC ANEMIA										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a CITRONIC VINE DISEASE										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) SUITLAND, MARYLAND		21f. LOCATION STREET 6501 LANDOVER RD.		CITY OR TOWN CHEVERLY, MD. 20785		COUNTY Arlington	STATE VA	
22a. I certify that (I) (this hospital) attended the deceased from MAY 1983 to JUNE 1985 , that (II) (we) last saw the deceased alive on JUNE 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (II) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Neil A. Meade		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 6-2-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NEIL A. MEADE, M.D.		22e. ADDRESS 6501 LANDOVER RD. CHEVERLY, MD. 20785								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5 June 85		23c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l		23d. LOCATION CITY OR TOWN Arlington			STATE VA	
24 FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home		ADDRESS Suitland, Maryland			25a. DATE REC'D. BY REGISTRAR JUN 11 1985		25b. REGISTRAR'S SIGNATURE Lia Landon Pendell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the time it is signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon copies. Pages 1 and 2 should be filled in within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



165007

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 5 17847

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
WILLIAM R. BOBICK						06	07	85	12.20	PM	
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White	09	09	1926	58		MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE				
Massachusetts		U.S.A.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OR PRINT MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
CHEVERLY		PRINCE GEORGES HOSPITAL AND MEDICAL CENTER			Salesman		Montgomery Wards				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)						13a. STREET ADDRESS / ZIP CODE					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	9418 Dogwood Park Street 20743				
Maryland	P.G.	Ritchie			13e. MOTHER'S MAIDEN NAME	LAST					
M. FATHER'S NAME FIRST		MIDDLE	LAST			FIRST	MIDDLE	LAST			
Albert		Francis	Bobick, Sr.			Mabel	Eleanor	Boisclair			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS				
Yes		W.W.II			579-26-3161		Margaret L. Bobick (Wife) Same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						<i>Cardiac arrest</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery disease</i>					
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
19b.					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>3/28</u> , 19 <u>85</u> , to <u>6/1</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>6/6</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Gerardo M. Gasch</i>						DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>6/1/85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>GERARDO M GASCH</i>		22e. ADDRESS <i>6492 Landover Rd. Landover MD</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/11/85	23c. NAME OF CEMETERY OR CREMATORIUM Maryland Veterans Cem.			23d. LOCATION CITY/TOWN Cheltenham	COUNTY P.G.	STATE Maryland			
24. FUNERAL DIRECTOR <i>Francis Gasch's Sons Funeral Home, P.A.</i> ADDRESS 4739 Baltimore Avenue Hyattsville, Md. 20781						25a. DATE REC'D. BY REGISTRAR <u>JUN 11 1985</u>	25b. REGISTRAR'S SIGNATURE <i>Sonia Davidson-Randall</i>				

COOK



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TO HOSPITAL OR ATTENDING PHYSICIAN. The

note be exercised within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper and mail to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 17848

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES H. BOLDING			2a. DATE OF DEATH 06 09 85	MONTH DAY YEAR	2b. HOUR 6:05A M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 02 17 1921	6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE COUNTRY Alabama	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY		
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL			12a. USUAL OCCUPATION Lab Foreman	12b. KIND OF BUSINESS OR INDUSTRY Consolidated News Photo Ctr
13a. STATE Maryland	13b. COUNTY P.G.	13c. CITY OR TOWN Bladensburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5446 Tilden Road 20710	
14. FATHER'S NAME FIRST John	MIDDLE W.	LAST Bolding	15. MOTHER'S MAIDEN NAME Leona	MIDDLE James	LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. W.W.II	17. INFORMANT Mary J. Bolding (Wife)	ADDRESS Same as 13e		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <i>sepsis, renal failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>5-18</u> , 19 <u>85</u> , to <u>6/9</u> , 19 <u>85</u> , that (I) (we) lost the deceased alive on <u>6/8</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Dennis F. Frank MD</i>			DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>6/9/85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dennis F. Frank MD</i>			22e. ADDRESS 1 Hosp Dr. Cheverly, MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6/12/85	23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery	23d. LOCATION Brentwood	23e. COUNTY P.G.	23f. STATE Maryland
24. FUNERAL DIRECTOR NAME Francis Gasch's Sons Funeral Home, P.A. ADDRESS 4739 Baltimore Avenue Hyattsville, Md. 20781			25a. DATE REC'D. BY REGISTRAR JUN 11 1985	25b. REGISTRAR'S SIGNATURE <i>Susan Anderson-Randall</i>	

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YOUNG & RUBICAM



1970 YOUNG & RUBICAM INC.

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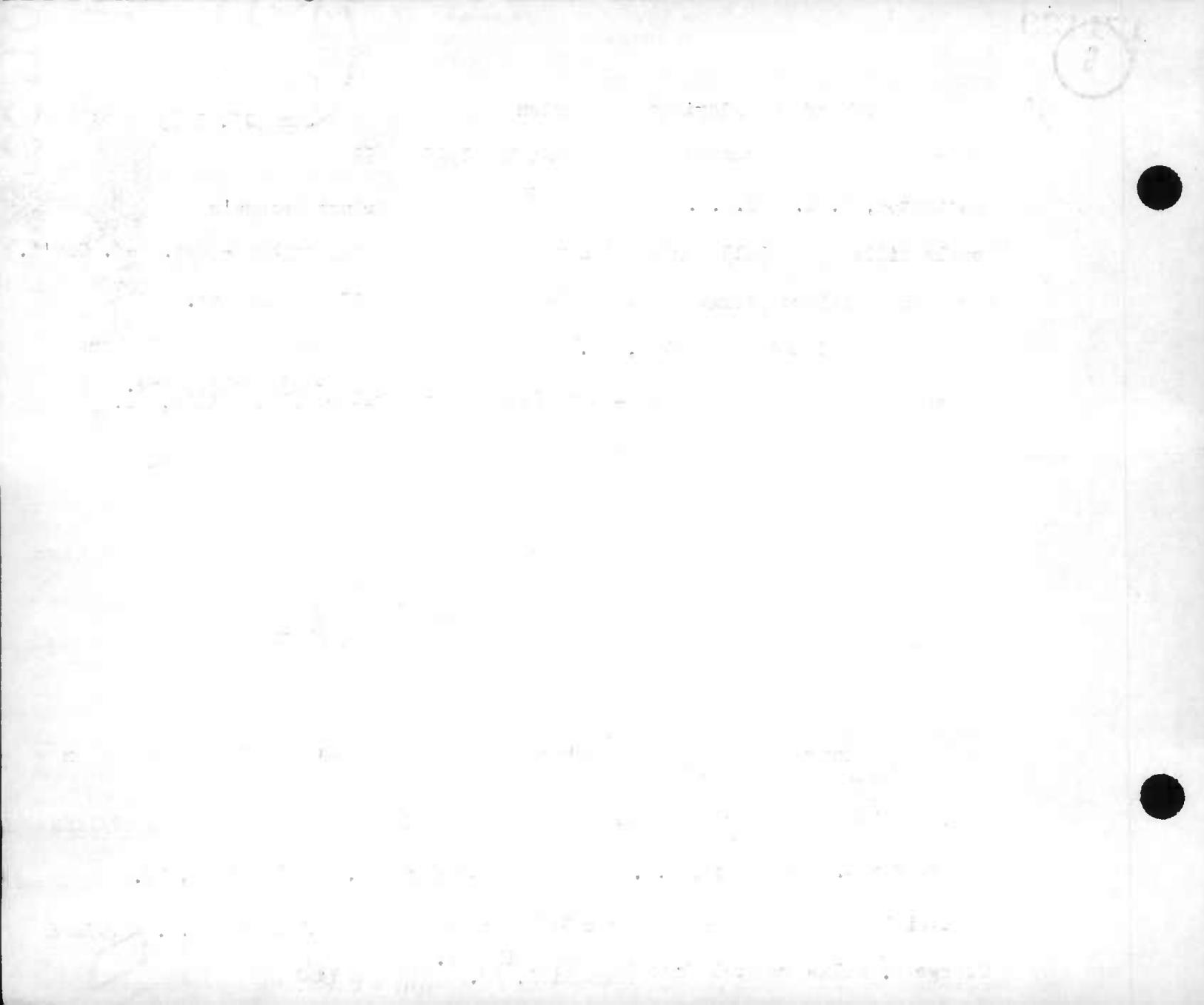
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 5 1 7 8 4 9
1. DECEASED NAME (TYPE OR PRINT) Edward Eldridge Bolen			2a. DATE OF DEATH June 15, 1985		MONTH DAY YEAR	2b. HOUR 5:25 PM
3. SEX Male		4. RACE Caucasian	5. DATE OF BIRTH August 10 1925		6. AGE (IN YEARS LAST BIRTHDAY) 59	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Temple Hills		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3213 Carlton Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lithographer - Ret. Fed. Gov't.	
13a. STATE Maryland		13b. COUNTY Prince George	13c. CITY OR TOWN Temple Hills	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3213 Carlton Ave. 20748	
14. FATHER'S NAME FIRST Thomas		MIDDLE Elwood	LAST Bolen, Sr.	15. MOTHER'S MAIDEN NAME FIRST Irma MIDDLE Lynwood LAST Goheens		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 578-40-2972		17. INFORMANT ADDRESS Rosa England Bolen 3213 Carlton Ave. Temple Hills, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for 18, 1b, and 1c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) J	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from June 19 75 , to June 15th 19 85 , that (II) <input type="checkbox"/> last saw the deceased alive on May 10th 19 85 , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If (I) <input type="checkbox"/> did not see the body after death, check here.)						
22b. SIGNATURE H. J. Chupkovich, M.D. DEGREE ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Victor S. Chupkovich, M.D.		22e. ADDRESS 3710 Riviera St. Temple Hills, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/19/85	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN Suitland COUNTY P.G. Maryland STATE	
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 18 1985				



179048

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, OR REMOVAL BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR CREMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 17850		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED			XX	MONTH	DAY	YEAR	2b. HOUR	
Terry			Lee	Bostic		6-22	1985			6-22	1985		M	
3. SEX	4 RACE	S. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD				MONTH	DAY	YEAR	2d. HOUR 2:35 p.m.	
Male	Black	July 20 59	25 yrs.	MONTHS	DAYS	HOURS	MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia			U.S.A.								Prince George's County, MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly			Prince George's General Hospital			Casher			Revolv					
13a. STATE Maryland			13b. COUNTY P.G.			13c. CITY OR TOWN Sea Pleasant			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 609 64th Ave 20743		
14. FATHER'S NAME FIRST Blanche			MIDDLE	LAST	Bostic	15. MOTHER'S MAIDEN NAME Alice Corwin			MIDDLE	LAST	Bostic			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. NO 577-90-5217			17. INFORMANT Jackie Bostic			ADDRESS 609 64th Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9684 IMMEDIATE CAUSE (a) Blunt Trauma to Head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 4:05 P.M. 6-14 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) subject was assaulted			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) baseball field			21f. LOCATION STREET Sheriff & Addison Rds., Fairmont Heights, CITY OR TOWN COUNTY Prince George's Co., STATE Md.								
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Dennis F. Smyth, M.D.													TITLE (SPECIFY) Assistant M.D.	MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.													DATE SIGNED 6-23-85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 6/29/85			23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Memorial			23d. LOCATION CITY OR TOWN Sunbury			COUNTY P.G.	STATE MD.	
24. FUNERAL DIRECTOR NAME			ADDRESS J. F. Jackson Esq 7474 London Rd			25a. DATE REC'D. BY REGISTRAR UN 25 1985			25b. REGISTRAR'S SIGNATURE Wilson Hendee					
BP														
DHMH - 17 (VR A15 ME (5))														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

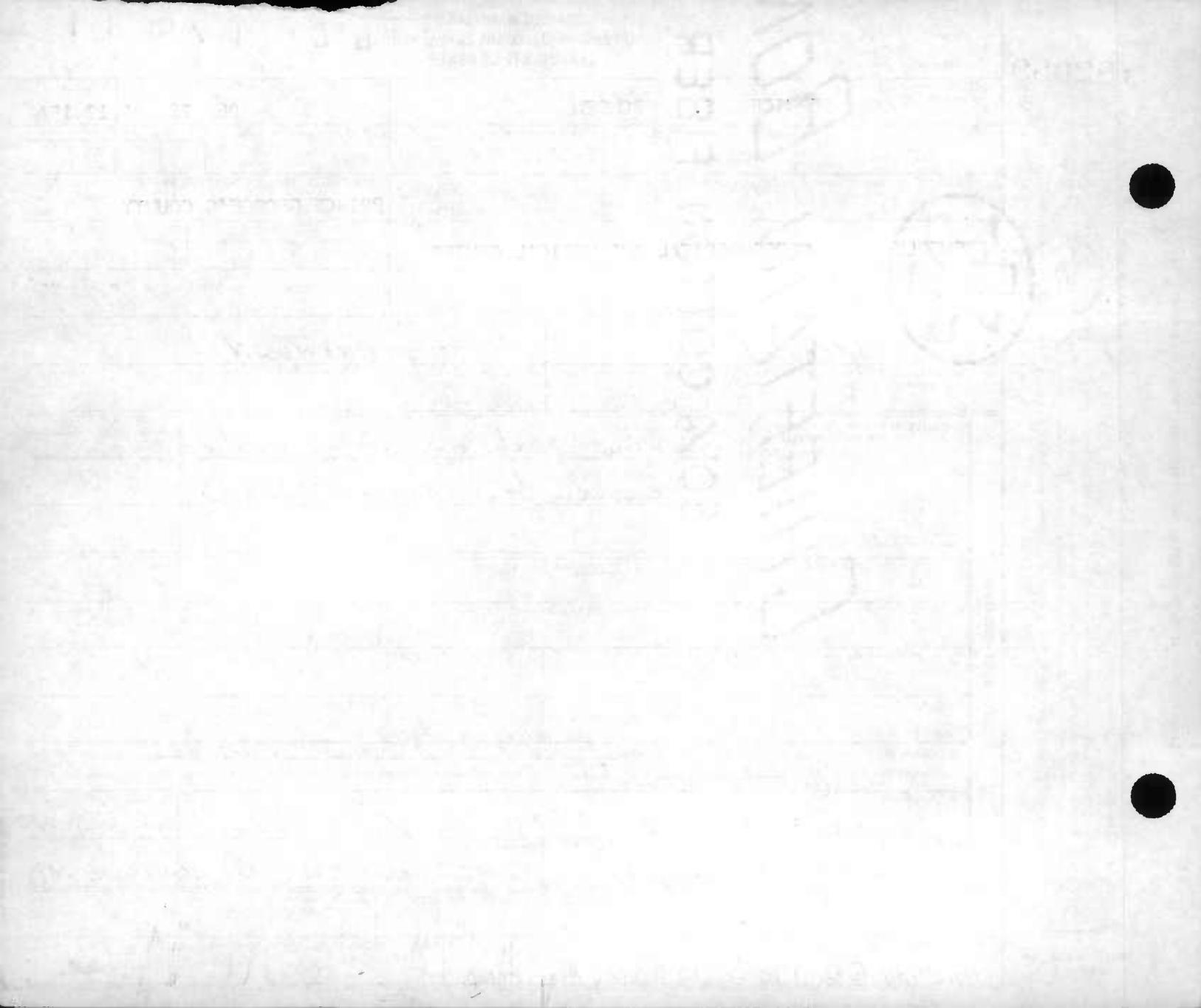
IMPORTANT: If Item 21 is marked or Item 18 showing injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 1785

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
BERNICE S. BOWDEN						06	26	85	12 15AM		
1. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White	Feb 1, 1899			86		YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
N. Carolina		USA					PRINCE GEORGE'S COUNTY MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
CHEVERLY		PGHOSPITAL AND MEDICAL CENTER			School Teacher		Public Schools				
13. STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Md		AACo	West River					1001 Cosimano Rd 20778			
FATHER'S NAME		MIDDLE	LAST			15. MOTHER'S MAIDEN NAME		MIDDLE LAST			
		Unknown				Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS				
no		579 34 3942			Anne Fowler # 13						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe cachexia & malnutrition											
DUE TO, OR AS A CONSEQUENCE OF (b) Severe far advanced COPD											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED <small>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/></small>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/21, 19 85, to 6/20, 19 85, that (II) (we) last saw the deceased alive on above, (II) (we) did not view the body after death.											
22b. SIGNATURE Gerardo M Gacad		DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/26/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GERARDO M GACAD		22e. ADDRESS 6492 LANDOVER RD. LANDOVER MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-29-85		23c. NAME OF CEMETERY OR CREMATORIAL Evergreen Mem Pk		23d. LOCATION Luray		CITY OR TOWN		COUNTY	STATE
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home		ADDRESS 12 Ridgely Ave Annap.		25a. DATE REC'D. BY REGISTRAR JUN 28 1985		25b. REGISTRAR'S SIGNATURE Davidson Pendell					



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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 1 7 8 5 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>William</i>	MIDDLE <i>E</i>	LAST <i>BRADLEY</i>	2a. DATE OF DEATH MONTH 05	MONTH DAY 05	YEAR 1930	2b. HOUR 6-28-85 8:35 a.m.		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH 05		DAY 05	YEAR 1930	6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.		
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Formen			12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't			
13a. STATE MD.		13b. COUNTY P.G.		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 212 N. Huron Dr. 20745		
14. FATHER'S NAME FIRST Slayden		MIDDLE 	LAST Bradley	15. MOTHER'S MAIDEN NAME FIRST Martha		MIDDLE E.	LAST Haynes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean 411-42-2153		17. INFORMANT Carolyn R. Bradley		ADDRESS 212 N. Huron Dr. Oxon Hill, Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (Typ 4 mo)	
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Squamous cell carcinoma of lung, Stage III</i>										
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) saw the deceased alive on 6-27-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7-6-85 to 6-28-85, that (I) (we) lost saw the deceased alive on 6-27-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										22c. DATE SIGNED 6-28-85
22b. SIGNATURE <i>Carl Y. Young Jr.</i>		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carl Y. Young Jr.		22e. ADDRESS 8926 Woodyard Rd #201 Clinton MD 20735								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-1-85		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cemetery		23d. LOCATION CITY OR TOWN Cheltenham		COUNTY P.G.	STATE Md.	
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		ADDRESS 6160 Oxon Hill Rd., Oxon Hill Md.		25a. DATE REC'D. BY REGISTRAR JUL 01 1985		25b. REGISTRAR'S SIGNATURE <i>Julie Davidson Pendle</i>				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 17853

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			DOROTHY	M	BRECHT	06	16	85	3.34PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		Jan 2, 1909		76 yrs.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Washington DC		United States				PRINCE GEORGE'S					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
CHEVERLY		PRINCE GEORGE'S GENERAL HOSPITAL		Housewife		Own Home					
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Pr Geo		Landover Hills				3839 64th Avenue 20784			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. ADDRESS		LAST		
		Julian		Trigger	Hattie		3109 N Bradford St		Inscoe		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		579-16-9924		Alice Munsell		Alice Munsell Dale City, Va 22193					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial infarction</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Diabetes Mellitus</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> A.T. WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>6-16</i> , 19 <i>85</i> , to <i>6-16</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>6-16</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Suresh C Gupta MD</i>		22c. DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Suresh C Gupta MD		22e. ADDRESS 3505 Perry St Mt Rainier MD 20822									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 20 June 85		23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		23d. LOCATION Suitland		CITY OR TOWN Suitland		COUNTY PG	
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home		ADDRESS Suitland, Md.		25a. DATE REC'D. BY REGISTRAR JUN 24 1985		25b. REGISTRAR'S SIGNATURE <i>Judith Davidson Pendleton</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84
(VRA 15, 4)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												5	1	7	8	5	4
												REG. NO.					
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR A					
			Mary Ann Broscius						6 - 9 - 85			10:50					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR					
F			W			6 - 6 - 1904			81 YRS.			MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Shenandoah, PA			U. S. A.						Prince George								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Mitchellville			Villa Rosa Nursing Home						Housewife			Self Employed					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
MD			Charles Waldorf									123 Lake Drive 20601					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS					
Anthony Zielinski			Mary			no 577-64-1775			Doris Broscius			32 Hunting Lane, Waldorf, Md. 20601					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: XXXX IMMEDIATE CAUSE (a) Aspiritive pneumonia												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Due to, or as a consequence of Aspiritive pneumonia																	
(c) Due to, or as a consequence of Dehydrated																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 6-7-1985 to 6-9-1985, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED								
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS						6-9-85								
Ciro A. Montanez MD			3308 Dodge PK Rd. Larchmont														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE								
Burial			6-13-85			St. Stanislaus Cem.			Shenandoah, Penn.								
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Huntt Funeral Home, Waldorf, Maryland						JUN 12 1985			Julia Davidson Pendleton								

CONFIDENTIAL

10:20 78 - C - 6 - 22
procaine 750 mg
N
C - C - 1804 81
Lizinc geoxes x
U.S.A. 200 mg
sparsusosis PA
housewife
less take time
MD Chrysote Waterton x
Anesthesia
Sedative
Benzodiazepine
Nov. 1979 3800
377-04-1777 effective date 30.10.1979
CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to you, it may be filed in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Please return the original to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION1 - FOR
STATE
REGISTRAR
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			EDNA	M.	BROWN	6/14/85				6:42p.m.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female	White	January 1, 1904			81	YEARS	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Staunton Va.	USA					PRINCE GEORGE'S COUNTY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
CLINTON	SOUTHERN MARYLAND HOSPITAL			Homemaker			Home				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE					
Maryland	Prince George	Forestville	YES <input type="checkbox"/> NO <input type="checkbox"/>			1900 Benson La. 20747					
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
James		Moneymaker	Ella				Lambert				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT	ADDRESS						
No	N/A 578 26 2709			Russell	1900 Benson La Forestville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (s) (this hospital) attended the deceased from <u>6-14</u> , 19 <u>85</u> , to <u>6-14</u> , 19 <u>85</u> . That (s) (we) last saw the deceased alive on <u>6-14</u> , 19 <u>85</u> , and that in (s) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (s) (did not) view the body after death.											
22b. SIGNATURE <i>William Kent Durst MD</i>			DEGREE			22c. DATE SIGNED <i>6/15/85</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. YOUNG, M.D.</i>			22e. ADDRESS 11701 Livingston Road Fort Washington, Maryland								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>Burial</i> June 18, 1985	23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery			23d. LOCATION CITY OR TOWN Rockville, Md.		COUNTY			STATE
24. FUNERAL DIRECTOR NAME <i>Lee F.H. Inc.</i>		ADDRESS 6633 Old Alexander Ferry Rd.			25a. DATE REC'D. BY REGISTRAR <i>JUN 21 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>				
DHMH - 16 60M 7/84 (VRA 15, 4)											

284
GOLDEN BEVERAGES



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17856

170102

REG. NO.

1-
FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b HOUR
ELIZABETH					BROWN	<input checked="" type="checkbox"/>	6	3	1985	

3. SEX	RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d HOUR
Female	Blk	11 16 '21	63					6	3	1985	8:18 P.M.	

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Prince George's County MD

11. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cheverly	Prince George's Gen. Hosp.	Stock Clerk	AAFB

13a. STATE Md.	13b. COUNTY Charles	13c. CITY OR TOWN Malcolm	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Rt 1 Box 1 Brandywine, Md.
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14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Hilton		Chesley	Wade		Butler

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	N/A	577 30 8077	Rachel Makle SAA

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8150		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF		
{ Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 5:28 M. 6-3- 1985	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Driver of auto/fixed object impact.
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1400 blk. Brandywine Rd., Prince George's, MD
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22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
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ACTUAL SIGNATURE 	TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	DATE SIGNED 6-4-85
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EXAMINER'S NAME (TYPE OR PRINT)	Ann M. Dixon, M.D.	ADDRESS 111 Penn St., Balto., MD 21201
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE Burial 6/18/ 1985	23c. NAME OF CEMETERY OR CREMATORIAL Christ UMC Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Aquasco, P.G. Md.
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24. FUNERAL DIRECTOR NAME 	ADDRESS Martell Adams Aquasco, Md. 20608	25a. DATE REC'D. BY REGISTRAR JUN 17 1985	25b. REGISTRATION SIGNATURE 
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501051



170061

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 17851

G

(TYPE OR PRINT)

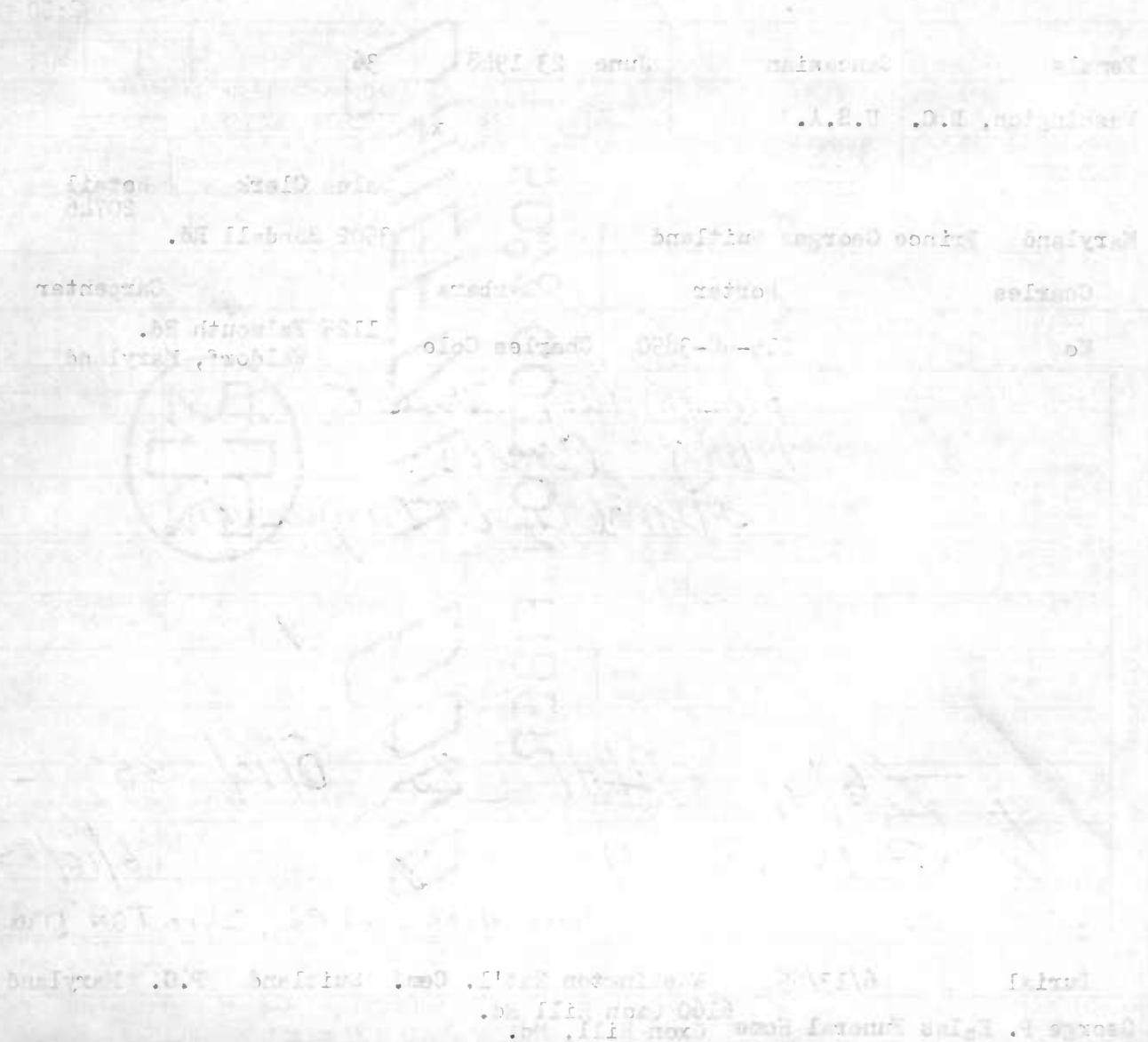
1. DECEASED NAME TERRI L. BROWN			2a. DATE OF DEATH 6/10/85	MONTH DAY YEAR	2b. HOUR 8:50 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH June DAY 23 YEAR 1948	6. AGE (IN YEARS LAST BIRTHDAY) 36	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.		
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk			12b. KIND OF BUSINESS OR INDUSTRY Retail
13a. STATE Maryland	13b. COUNTY Prince Georges Suitland	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3502 Randall Rd. 20746	
14. FATHER'S NAME FIRST Charles	MIDDLE LAST Porter	15. MOTHER'S MAIDEN NAME FIRST Barbara	MIDDLE	LAST Carpenter	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 219-48-3850	17. INFORMANT Charles Cole	1125 ADDRESS Falmouth Rd. Waldorf, Maryland		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Respiratory arrest lung cancer spinal cord compression					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF (b) lung cancer DUE TO, OR AS A CONSEQUENCE OF (c) spinal cord compression					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (his/her) attended the deceased from below: the deceased alive on 6/9/85 and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (II) (we) did not view the body after death.	19 85	10	6/10/85	19 85	10
22b. SIGNATURE <i>L. Berwa MD</i>	DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 6/10/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. BERWA, M.D.	22e. ADDRESS 9015 Woodyard Rd., CLINTON, MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6/13/85	23c. NAME OF CEMETERY OR CREMATORIAL Washington Nat'l. Cem.	23d. LOCATION CITY OR TOWN Suitland	COUNTY P.G.	STATE Maryland
24. FUNERAL DIRECTOR George P. Kalas Funeral Home	25a. DATE REC'D. BY REGISTRAR JUN 17 1985	25b. REGISTRAR'S SIGNATURE <i>George P. Kalas Funeral Home</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

130037



170110

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF PENDING, IN PENCIL IN ITEM 1B, GIVE PAGES 1 AND 2 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM TM 3A. PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 17853								
1. DECEASED NAME (TYPE OR PRINT)			FIRST Marguerite MIDDLE Brunelle			L. Brunelle			2a. DATE KNOWN OF ESTI- MATED			MONTH DAY YEAR		2b. HOUR						
Marguerite									<input type="checkbox"/>			6-7 1985		M						
3. SEX		4. RACE		DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEATH		MONTH DAY YEAR		2d. HOUR				
Female		White		Aug. 13 1901		83 RS.		MONTHS DAYS		HOURS MIN.		6-7		1985		330 AM				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Pr. Geo.					
Maryland			U.S.A.									Ret. Executive			Sec.-U.S. Govt.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Cheverly			Pr. Geo. Hospital			Ret.			Executive			Sec.-U.S. Govt.								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS								
Md.			Pr. Geo.			Mt. Rainier						3810- 31st St. 20712								
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME														
George			H. Lilliey			Dora						Watkins								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS											
No			578-32-3515			Barbara A. Ward - above address (Dtr.)														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Diseases of heart and vascular disease																				
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																				
(b)																				
DUE TO, OR AS A CONSEQUENCE OF																				
(c)																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?								
												<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE												M.D. Deputy MEDICAL EXAMINER								
EXAMINER'S NAME (TYPE OR PRINT)												ADDRESS 5209 Poplar Cr. Camp Springs, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE					
Burial			6/10/1985			Ft. Lincoln Cem.			Brentwood			Pr. Geo. Md.								
24. FUNERAL DIRECTOR NAME			Nalley's F. H. Inc.			Mt. Rainier, Md.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
									JUN 13 1985			John Davidson-Randall								
DHMH - 17 (VR A15 ME (5))																				

CHICK

Septem

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Released by Dr Rodriguez - M.C.O.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it may be filed in the funeral director's office. Then please remove carbon copies. Please send the original to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

163101

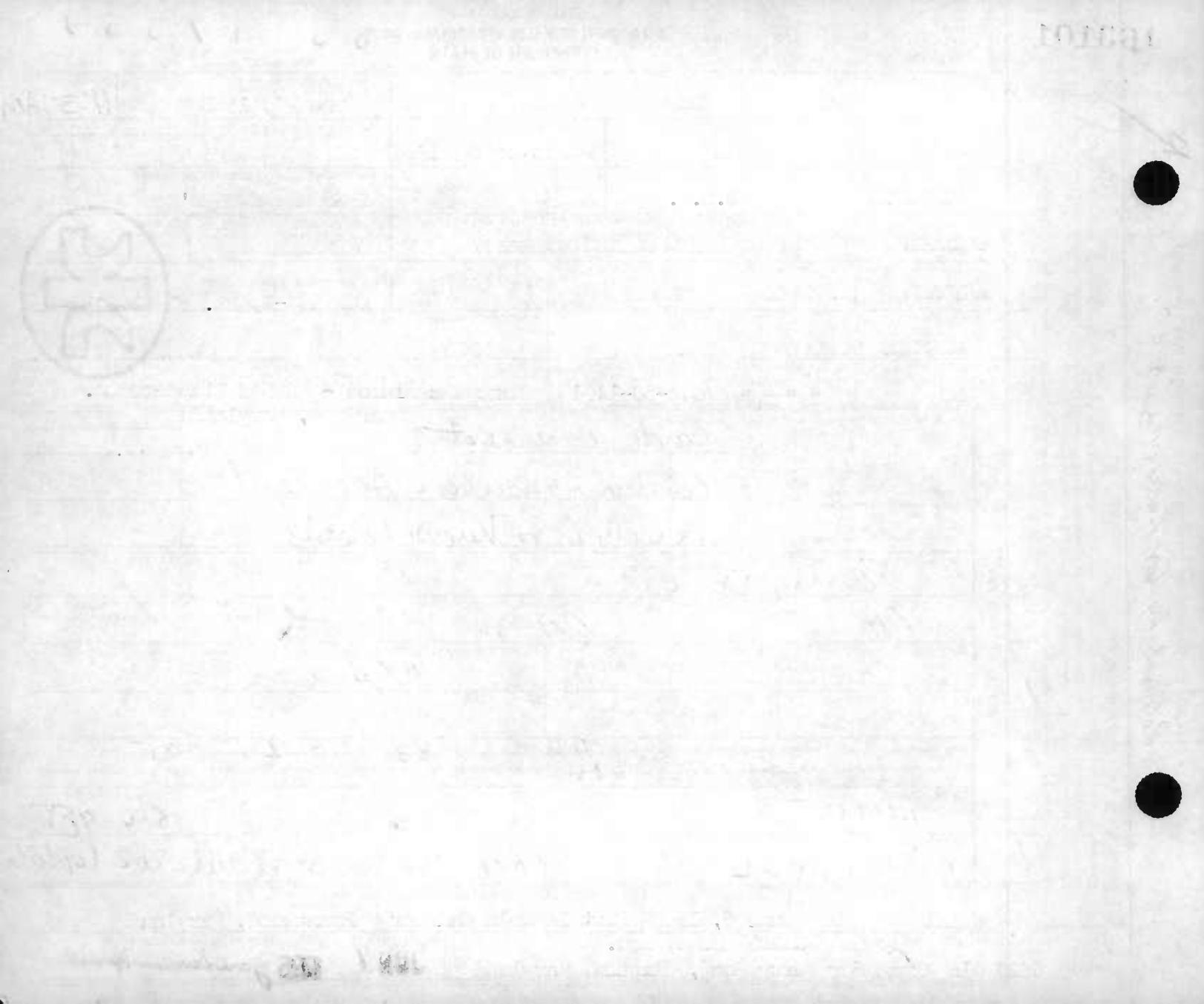
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 5 17859

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
RUTH SMITH BUCK						June 3, 1985				11:37 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
FEMALE		WHITE		MONTH December DAY 21, YEAR 1894		IF UNDER 1 YEAR			MONTHS DAYS HOURS MIN.		
a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
VIRGINIA		U.S.A.				PRIN CE GEORGE'S					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
CLINTON		SOUTHERN MARYLAND HOSPITAL				HOMEMAKER					
13a. STATE MARYLAND		13c. CITY OR TOWN CHARLES		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE BOX 294-A, Rt. #1 20601					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST				
RICHARD		ALFONZO	PACE	MARY		GREGORY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. NO * * * *		16c. INFORMANT		ADDRESS					
		578-50-1404		Nancy Messinese - 1509 E Flanders Ln.		Harwood, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
cardiac arrest											
DUE TO, OR AS A CONSEQUENCE OF (b) carbo-vascular accident											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (c) genuinely Atherosclerosis											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Senile Demencia</i>											
19a. DATE OF OPERATION <i>w/PA</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>2/09</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2) <i>2/14</i>							
21d. INJURY OCCURRED <i>NOT WHILE AT WORK</i>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>1/16</i> , 19 <i>83</i> , to <i>6/2</i> , 19 <i>85</i> . that (I) (we) last saw the deceased alive on <i>6/1</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>A.H. FADUL</i>		DEGREE				22c. DATE SIGNED <i>6-4-985</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A.H. FADUL</i>		22e. ADDRESS <i>616 Charles St. Suite 202 (opposite</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 6, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood, Maryland		COUNTY	STATE		
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. ADDRESS 6633 Old Alexander Ferry Road, Clinton, Maryland						25a. DATE REC'D. BY REGISTRAR JUN 7 1985		25b. REGISTRAR'S SIGNATURE <i>Jeanne Johnson Pendleton</i>			
DHMH - 16 60M 7/84 (VRA 15, 4)											



156138

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

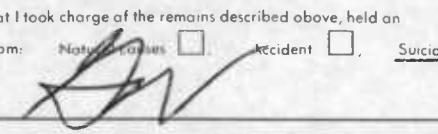
MEDICAL CERTIFICATION

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17860

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Darryl	MIDDLE A.	LAST Bunch	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	MONTH 6 /	DAY 1	YEAR 1985	2b. HOUR 5:40 M
3. SEX male	4. RACE Black	5. DATE OF BIRTH MONTH 7	DAY 1	YEAR 67	6. AGE IN YEARS LAST BIRTHDAY 17 YRS.	IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		2c. DATE PRONONCED DEAD 6 / 1 / 1985		
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7007 Highview Terrace			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) stock boy			12b. KIND OF BUSINESS OR INDUSTRY retail	
13a. STATE Md.	T3b. COUNTY Prince George	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 7007 Highview Terr.			
14. FATHER'S NAME FIRST Jerry		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Catherine		MIDDLE	LAST	Allen	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 076-50-6229			17. INFORMANT ADDRESS Catherine Maxey 35 Ann St. Ossining, N.Y.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun Wound to Head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 6 / 1 / 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self inflicted wound					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET 7007 Highview Ter.		CITY OR TOWN Hyattsville	COUNTY P.G. Co.	STATE Md.	
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.		DATE SIGNED 6/2/85							
23a. BURIAL, CREMATION, REMOVAL IS PENDING Burial		23b. DATE 6/5/85		23c. NAME OF CEMETERY OR CREMATORIAL Dale Cemetery		23d. LOCATION CITY OR TOWN Westchester			COUNTY N.Y.
24. FUNERAL DIRECTOR NAME Barley Douglass		ADDRESS 1348 N. Calhoun St.		25a. DATE REC'D. BY REGISTRAR JUN 3 1985			25b. REGISTRAR'S SIGNATURE 		
ADDRESS (VR A15 ME (5))									

12570



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon paper. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 1 7 8 6 1		
												REG. NO.		
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			January 30 1916			6 27 85			1:50 P.M.		
3. SEX Female			4 RACE Black			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE Prince George's			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.					
10. CITY OR TOWN OF DEATH Clinton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Southern M.H. Hospital			12a. USUAL OCCUPATION Housewife			12b. KIND OF BUSINESS OR INDUSTRY N/A					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland Prince George's Upper Marlboro												13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? XXX	13e. STREET ADDRESS / ZIP CODE 11302 Van Brady Rd. 20772
14. FATHER'S NAME John (NMN) Proctor			15. MOTHER'S MAIDEN NAME Cora E. Proctor											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No			16b. SOCIAL SECURITY NO. N/A 579 18 4363			17. INFORMANT Richard Mortimer Butler			ADDRESS 11302 Van Brady Rd. Upper Marlboro, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Ig G kappa multiple myeloma												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs 1 mo		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from May 19, 82, to June 19, 85, that (I) (we) last saw the deceased alive on 6-27-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Lee-Yin Young</i>			22c. DEGREE <i>B.S. 1950</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 6-28-85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lee-Yin Young</i>			22e. ADDRESS 8926 Woodyard Rd # 201 Clinton, Md 20735											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jult 2 1985			23c. NAME OF CEMETERY OR CREMATORIAL Resurrection			23d. LOCATION CITY OR TOWN Clinton Prince George's Md.					
24. FUNERAL DIRECTOR Lee Funeral Home Inc. 6633 Old Alexander Ferry Rd Clinton, Md. 20735						25a. DATE REC'D. BY REGISTRAR JUL 05 1985			25b. REGISTRAR'S SIGNATURE <i>Jean Davidson Pendell</i>					



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164082

1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 1 7 3 6 2
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
<i>Martha</i>			<i>E</i>	<i>Butler</i>		<i>6 4 85</i>				<i>8:30 A.M.</i>
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	7. IF UNDER 21 HRS		
<i>Female</i>		<i>Black</i>	MONTH	DAY	YEAR	<i>57</i>	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
<i>Washington, D.C.</i>		<i>U.S.A.</i>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	<i>PRINCE GEORGE'S</i>			MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A HOSPITAL, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
<i>Clinton</i>		<i>Southern Md. Hospital</i>								
13. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
<i>Md.</i>		<i>St. Mary's</i>	<i>Bushwood</i>				<i>Den Del. 20618</i>			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
<i>Benjamin</i>			<i>Countiss</i>	<i>Mary</i>			<i>Parr</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS		
<i>No</i>		<i>215-26-0642</i>			<i>Charles Sylvester Butler</i>			<i>Same as 13e.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Severe Malnutrition</i>)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Advanced Carcinoma of pancreas.</i>										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Edema. Acetitis. Congestive Heart failure.</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>6-3</i> , 19 <i>85</i> , to <i>6-4</i> , 19 <i>85</i> . that (I) (we) last saw the deceased alive on <i>6-4</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED <i>6-4-85</i>
22b. SIGNATURE <i>Cyrus V. Parsey M.D.</i>		DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Cyrus V. Parsey M.D.</i>		22e. ADDRESS <i>8700 Old Branch Ave Clinton Md 20735</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>5/7/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Sacred Heart Cem.</i>			23d. LOCATION <i>Bushwood St. Mary's Md.</i>			
24. FUNERAL DIRECTOR NAME <i>W. Clarke Mattingley, Leonardtown, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 10 1985</i>			25b. REGISTRAR'S SIGNATURE <i>John Andrew Pendleton</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 may be retained by the hospital or attending physician with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

3011

